Registration and Medical Release

Client Name _____ **Date of Birth** _____
(Exactly as appears on Medicare/Insurance card)

Address _____ **Apt No.** _____

City _____**ZIP**_____ **Phone** _____

Social Security Number _____ **Race** _____ **Sex** _____

Services Requested

I request the following vaccination(s) from the Florida Department of Health in Pinellas County:

☒ Influenza (flu shot)

Health Insurance

☐ Medicare B - **Medicare Policy Number (copy from card if applicable):** _____

☐ HMO/Other Insurance ☐ DOH Employee ☐ None

I have requested vaccination services from the Florida Department of Health in Pinellas County as indicated above. I have received and understand information provided in the Vaccine Information Statements.

Medicare Patient Certification, Authorization to Release and Payment Request – As client/representative signed below, I certify that the information I have given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the Florida Department of Health in Pinellas County to release protected health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the Florida Department of Health in Pinellas County and authorize it to submit a claim to Medicare for payment.

Assignment of Benefits (only applies to third party payers) – As Client/Representative signed below, I, assign to the Florida Department of Health in Pinellas County all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to the above agency. **I am personally responsible for charges not covered by this assignment.**

Date _____ **Signature** _____

-OR-

Name of Legal Representative _____ Relationship to Client_____

Signature of Legal Representative _____

Witness Name_____Witness Signature_____Date_____

– OFFICE USE ONLY –

☐ **Influenza (Flu 3Y+ PF)**	**Lot #** _____	☐ **Walk in** ☐ **Drive Thru; # in car**_____
	Mfg _____ **Init** _____	**Form Check/Triage:** _____
☐ **High Dose Influenza (65y+)**	**Route**_____ **Site** _____	**Dispensing:** _____
		Checkout: _____